Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: J. THOMAS DILGER JR., M.D. 6718 Montay Bay Drive Spring, Texas 77389	MFDR Tracking #: M4-09-6187-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: AMERICAN HOME ASSURANCE CO REP. BOX # 19	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary as stated on Table of Disputed Service: "Designated Doctor Exam"

Principle Documentation:

1. DWC 60 package
2. CMS-1500
3. EOB(s)
4. Total Amount Sought - $1,225.00.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "In reviewing the report, it is the carrier's position that the medical bill was originally denied on 12/21/2006 as the provider billed with an invalid code, which per TX rules, we cannot pay any part of a bill when there is even one invalid code. The provider sent in a corrected code on reconsideration but that was not done until 4-29-2008, so it was denied again, as it was well beyond the timely filing requirements set by the state. With that said, the carrier has decided to go ahead and pay the provider without interest since we have never received the reconsideration bill from the provider until well over a year after the initial bill was denied for just cause."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service(s)	Amount in Dispute	Amount Due
09/11/2006	16, W1, 172	99456 (listed as 99456-WP on CMS)	$650.00	$0.00
09/11/2006	16, W1, 172	99456 (listed as 99456-WP on CMS)	$150.00	$0.00
09/11/2006	16, W1, 172	99456 (listed as 99456-WP on CMS)	$150.00	$0.00
09/11/2006	16, W1, 172	99456 (listed as 99456-WP on CMS)	$150.00	$0.00
09/11/2006	181, 172	96118 (originally billed as 96117)	$125.00	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. Medical Fee Dispute Resolution (MFDR) received the DWC-60 on 02/17/09. The date of service in dispute is 09/11/06.

2. 28 TAC Section 133.307 (c) (1) (A) states in part, "A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

3. This dispute was not submitted timely.

4. Nevertheless, communication with the Respondent produced information showing that an amount of $800.00 was processed. While less than the $1,525.00 sought, it represents an amount that the carrier paid in good faith. Verification of receipt of this payment was not provided upon request.

5. The Division concludes that this dispute was not filed in the form and manner prescribed under Rule 133.307 Section (c) (1) (A). As a result, the amount ordered in $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 TAC Sec.§ 133.307 (c) (1) (A)

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

		12/16/2009
Authorized Signature	Medical Fee Dispute Resolution Auditor	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.